RELEASE OF PHYSICIAN-SPECIFIC QUALITY OF CARE INFORMATION: LEGAL ISSUES

James B. Simpson, J.D., M.P.H.

Western Consortium for Public Health

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I. INTRODUCTION

Information and markets

The availability of product information to consumers is a basic requisite of competitive markets. In fact, the competitiveness of markets is measured in part by the presence or absence of barriers to obtaining facts about the price and quality of products or services offered. Although there is often debate over the marginal value of additional information to consumers, there are few markets for which the argument has ever been seriously advanced that consumers ought to be less rather than more informed.

The medical care market is such an exception. It is said that factual information about the nature of medical services ought to be withheld from, or at least not actively provided to, consumers for several reasons. A traditional rationale has been that information about the nature of medical services is so complex, and judgments based on such information so discretionary that consumers will either ignore the information they are given or ignorantly misjudge it to the detriment of their health.

Standing alone, this rationale seems inadequate, if for no other reason than that consumers have access, if they choose to exercise it, to information about many equally complex products and services intimately affecting their lives, from automobiles to consumer credit. However, the argument is usually coupled with a subsidiary point: physicians, acting as agents for patient-consumers, stand ready to make judgments about medical services on their behalf.

In recent years our society has become increasingly distrustful of physicians, hospitals, and other health care providers as reliable, disinterested agents for patients in making decisions about the cost and quality of health services. Enormous increases in total expenditures for medical care have highlighted the conflicting incentives of personal gain and patient health confronting health care providers acting as agents for consumers. At the same time, the expansion of medical benefit programs and of data collection and retrieval systems has made it possible to produce voluminous financial, utilization, and outcome data concerning medical care. Interest in making such information available to consumers in order to increase the competitiveness of markets for medical services has increased dramatically in recent years.[1]

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[1] For an excellent survey of research in the health consumer information field, see Marquis, Kanouse, and Bradsley, Informing Consumers About Health Care Costs: A Review and Research Agenda (Rand/UCLA Center for Health Care Financing Policy Research 1985).

Physician-specific vs. patient-specific data

Debate over the collection and dissemination of information about the quality of physician services is often colored by the personal nature of the services provided. Few persons would dispute that patients have an interest in the confidentiality of information about the medical care they receive.[2] However, modern data management and computer file purging techniques make it technically feasible to compile and disseminate information about medical care provided by individual physicians without explicitly identifying individual patients. It is consequently practicable to consider the release of physician-specific data independent of the question of disclosure of patient information. In this report I will assume that all forms of physician-identified information under consideration for purposes of assessing quality have been, or are capable of being,[3] purged of patient identifying information.

It is important to recognize the extent to which the thorny legal issues and problems customarily associated with release of medical information are either bypassed or greatly diminished in the case of data that associate individual physicians with medical care outcomes but does not personally identify their patients. The personal interests protected by legal rules governing confidentiality of patient-identified records-avoiding humiliating disclosure of personal information and encouraging frank patient-physician communication-are not implicated by disclosure of physician data. Consequently, as Section II of this report indicates, the various statutes and court decisions concerning the collection and dissemination of information about physician outcomes often treat physician-identified information significantly less restrictively than patient-identified information.

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2 The Supreme Court has indicated that a patient's interest in the privacy of medical records pertaining to him has a constitutional dimension, although it may be outweighed by countervailing public concerns. Whalen v. Roe 429 U.S. 589, 602, 97 S.Ct. 869, 878 (1977).

3 Note that physician-identified information that does not explicitly identify a patient may implicitly do so. If, for example, a physician treats only one patient for a particular disorder, or has only one patient in a community, the patient may be implicitly identified. I will assume in this report that the physician-identified information under discussion does not implicitly identify individual patients. For an analysis of problems and questions associated with implicit identification, see Simpson, PRO Release of Outcome Data: Legal Issues (paper prepared for American Medical Review Research Center Peer Review Outcome Data Conference (April 1987).

Jurisprudential approach to data disclosure

Legal analysis, particularly in areas of non-statutory law, often consists of the identification and balancing of the competing interests of parties to a dispute. Although much of the law concerning data disclosure is statutory, as we shall see in Section II the concept of interest-weighing has found its way into these statutes, often through judicial interpretation of their meaning.

The calculus of interests

Several identifiable interests vie for attention in the analysis of physician-identified data collection and disclosure. The most prominent are a public interest in disclosure to enhance the competitiveness of medical markets (on price and quality dimensions), and a private interest of some physicians in nondisclosure to shield their professional reputations. The public interest in disclosure is premised upon the existence of a market for physician services and the effectiveness of competitive markets to advance public interests. It is also premised on the belief that physician-identified data will have an effect on that market, i.e., that the information will not be too complex, conflicting, or ambiguous for consumers to absorb, and that consumers, not physicians or others acting as their agents, are the decision-makers with respect to purchase of medical care.

The strength of the public interest in disclosure, and the weight it would carry in a legal analysis, might depend in part on the credibility or evidentiary support for the above-noted assumptions. If they were doubtful, the public interest could shift in favor of non-disclosure. For example, if physician-identified data were complex, ambiguous, or misleading, the public interest might lie in nondisclosure to prevent patients from mistakenly avoiding good doctors or seeking out poor ones, or to protect the reputations of physicians from falsely adverse information. On the other hand, the presence of agents or proxies for individual consumers such as insurers, health plans, and employers, with parallel quality preferences and a greater ability to master complex medical data, might diminish this concern.

Although at least some physicians would probably always have an interest in nondisclosure, the interests of physicians would not necessarily uniformly favor nondisclosure. The professional reputations and economic interests of some physicians would be enhanced by release of outcome data. The reputation of the medical profession in general might be enhanced by disclosure, both in the sense that it might reveal the infrequency of negative outcomes of medical care and that it might purge the profession of its incompetent members. Data release might alert well-meaning physicians with poor outcome records to a need for additional training or a change in their practice patterns.

However, some less competent physicians would presumably always have an interest in nondisclosure, and all physicians would have an interest in nondisclosure of information that was too complex, ambiguous, or misleading to inform consumers. In this sense the physician interest in disclosure, like the public interest, turns in part on the quality and credibility of the information disclosed, and on its probable impact on the market.

Other interests can be identified. If given a choice, the public may have an interest in regulation of medical markets through consumer choice based on disclosed information rather than governmental regulation or professional self-monitoring. Market incentives may be more efficient and less costly than regulatory controls. Disclosure of data on physician outcomes may also enable the public to evaluate the performance of governmental regulation or professional self-monitoring.[4] For physicians these alternatives might carry differing values too, with the neutrality of the market preferable to government regulation if self-regulation by the profession were not possible.

The public, or government, would have a strong interest in the impact of widespread outcome data disclosure on the supply and price of physician services to the public at large and to governmental payors. Increased information disclosure might decrease the supply of physicians by driving marginal providers out of the market. It could make services unavailable in some geographical areas, decrease competition in others, or reduce the availability of physician services to low-income consumers. It could encourage physicians to select healthier patients, in a process analogous to "adverse selection" of insurance risks, with resulting diminished availability of care to those most in need. Disclosure could encourage malpractice litigation, increasing malpractice premiums and, correspondingly, patient charges. The threat of disclosure could discourage entry into the profession. Perhaps more importantly, it could discourage existing practitioners from entering specialties, especially those for which the level of physician experience was a factor in patient outcome. Finally data disclosure could discourage desirable innovation in medical practice, at least where the risk of adverse outcomes from an innovative practice was unknown, or initially high.

Weighting of public and private interests

The authority of government to protect the public's health is broad, and courts are highly deferential to legislative judgments in the health field.[5] As a result, in a general sense law and legal rules applicable to physician-identified quality data are

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[4] I am in indebted for this point to INSTITUTE OF MEDICINE, ACCESS TO MEDICAL REVIEW DATA: DISCLOSURE POLICY FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS 83-84 (1981).

[5] See generally WING, THE LAW AND THE PUBLIC'S HEALTH (1984).

likely to value the public interests affected more highly than the professional and commercial interests of physicians. However, this principle does not mean that the applicable legal rules invariably favor disclosure. First, in various ways the law protects individuals against excessive or unfair intrusion by government into their private affairs. If a physician interest in nondisclosure can be characterized as "personal" or "reputational" rather than commercial, its protection may outweigh disclosure. Second, legal rules (and the court that administer them) treat governmental actions potentially adverse to individuals more favorably when the government proceeds in accordance with certain procedural norms designed to prevent arbitrary, unannounced, or inequitable results. The legality of physician outcome data disclosure efforts may turn on the extent to which such efforts comport with principles of due process and fair procedure in implementing such efforts.[6]

As Section II of this report indicates, legislatures and government agencies have tended to favor either nondisclosure or disclosure only to official groups assigned the task of monitoring and regulating medical services. It is likely that this tendency arises out of combined concern for the impact of disclosure on practitioners and scepticism as to the ability of consumers to use the data.

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[6] See, e.g., the detailed prior notice and comment procedures for disclosure of nonconfidential hospital-specific outcome data by PROs, discussed in Simpson, supra note 3.

II. CURRENT LEGAL ENVIRONMENT

This section discusses the current legal environment pertaining to collection and dissemination of physician-identified information of several types:

- o physician-specific medical record outcome data
- o records of adverse events in hospitals
- o official disciplinary actions
- o private disciplinary actions
- o malpractice judgments

The emphasis is on describing current statutory requirements for, and prohibitions on, collection and release of physician-identified data. For each category of information, this section will discuss current systems for collection and dissemination by the federal government (and federal contractors), state government agencies, and private organizations.

A. Physician-specific medical record outcome data

There are several systems in existence for collection of physician-specific medical record outcome data.[7]

1. Federal government collection and dissemination of Medicare data

The most likely federal source of physician-specific, medical record-type outcome data is the Medicare program. For example, the Medicare inpatient hospital billing form, UB-82/HCFA Form 1450, requires identification of the attending physician and the patient's disposition. Medicare claims using the UB-82 are obtained initially by private Medicare fiscal intermediaries or carriers, and subsequently by the Health Care Financing Administration (HCFA). HCFA maintains a Medicare Statistical System which includes a 100 Percent Medicare Utilization File comprised of all filed claims, and a detailed file, known as the Medicare Provider Analysis and Review or "MEDPAR" file, based on a 20 percent sample of inpatient hospital bills. The MEDPAR file is, in effect, a discharge data set similar to those created by private hospital discharge data services or mandated by state health data statutes.[8]

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[7] The term "physician-specific medical record outcome data" is intended to encompass medical record information and health care data abstracted from medical records, including but not limited to hospital data such as mortality or morbidity rates per physician.

[8] Scanlon, James and Winderlich, Gooloo, Health Data Inventory FY1983-84, report prepared for DHHS Health Information Policy Council, NTIS (1984). See discussion of state health facility data reporting statutes infra.

The legal rules surrounding disclosure of Medicare data by HCFA are somewhat complex. Records and data collected by a federal agency such as HCFA are subject to the Freedom of Information Act (FOIA) and the Privacy Act.[9]

The FOIA generally provides that any person has a right, enforceable in court, of access to federal agency records. There are several exemptions from the mandatory disclosure requirements of the FOIA. Under them an agency may, but is not required by the FOIA to, refuse to disclose information.[10]

The Privacy Act, whose stated purpose is to safeguard individuals against an invasion of privacy by federal agencies, prohibits disclosure of records pertaining to an individual without his/her prior written consent. Several exceptions permit release of data on identifiable individuals.[11]

Records and data collected under the Social Security Act are subject to additional requirements. The Act forbids disclosure of any record or information obtained thereunder, except pursuant to regulations adopted by the Dept. of Health and Human Services (HHS) or as otherwise provided by Federal law.[12] HHS has adopted a single set of regulations to implement Section 1106,[13] and the FOIA and Privacy Act as they pertain to Medicare. The regulations provide generally that the Department's policy is one of full disclosure, limited only by obligations of confidentiality and administrative necessities recognized by the FOIA.[14]

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10 5 U.S.C.A. §552; 552a. Chrysler Corp. v. Brown 441 U.S. 281, 99 S.Ct. 1705 (1979). The exemptions are for: (1) national security information, (2) internal agency personnel rules, (3) matters specifically exempted by statute, (4) trade secrets and confidential commercial and financial information, (5) interagency memoranda, (6) personal and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, (7) law enforcement records, (8) financial regulatory agency records, and (9) certain geological data.

11 Disclosure is permitted for use within the agency, FOIA compliance (i.e., disclosure not prohibited by one of the nine FOIA exemptions), routine use (i.e., uses compatible with the purposes for which the data was collected), census use, statistical research stripped of personal identifiers, national archives, law enforcement, emergency circumstances, congressional committee and GAO use, and disclosure pursuant to court order.

12 Soc. Sec. Act § 1106(a); 42 U.S.C.A. §1306(a).

13 See 42 C.F.R. §§401.101-152 (1986). See also 45 C.F.R. §§ 5.1 et seq. (1986) which contain general rules for release of information by HHS.

14 45 C.F.R. §5.12 (1986).

Under the regulations and guiding statutes, could a consumer or consumer representative demand that Medicare claims information containing physician-identified medical record outcome data be made available? Assume, for example, that HCFA had created a record based on Medicare claims data which associated individual physicians with patient mortality, morbidity, or other outcome measures of quality but did not personally identify individual patients.[15] Assume that disclosure is opposed by individual physicians.

First, under the Privacy Act HHS could not disclose such information without the consent of the identified individual physicians, unless the disclosure fell within one of the Privacy Act's exceptions. The most likely choice would be the exception for information required to be disclosed (i.e. non-exempt) under the FOIA. In turn, the FOIA exemptions which might apply to a disclosure of physician-identified Medicare claims data would be

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[15] The FOIA does not require, and HHS has not voluntarily agreed to, create new records on request from raw Medicare data or files in its possession. 42 C.F.R. §401.120 (1986).

Exemptions 4 and 6.[16]

Exemption 4

Exemption 4 applies to "trade secrets" and information which is "commercial or financial, obtained from a person, and privileged or confidential".[17] Physician-identified medical record outcome data might possibly qualify as "commercial" information under Exemption 4. In Public Citizen Health Research Group v. F.D.A. 704 F.2d 1280 (D.C. Cir. 1983) the D.C. Circuit Court of Appeals held that data submitted to the FDA by intraocular lens manufacturers relating to the incidence of adverse reactions during their ongoing clinical studies was commercial information exempt from disclosure under Exemption 4. The Court reasoned that a firm could have a commercial interest in data concerning clinical results, because documentation of the health and safety experience of the firm's products would be instrumental in gaining marketing approval. In the case of physician-identified

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16 Exemption 3, (matters "specifically exempted from disclosure by statute ...") could conceivably apply. As noted in the text supra, Section 1106(a) of the Social Security Act prohibits disclosure of Medicare information "except as the Secretary may by regulations prescribe." Against repeated arguments that this language constitutes a statutory disclosure exemption, the courts have held that Section 1106(a) is not an exemption statute within the meaning of Exemption 3, because it merely grants discretion to HHS to exempt without "specifically" exempting any data by its own terms. See Parkridge Hospital, Inc. v. Blue Cross and Blue Shield of Tennessee 430 F.Supp. 1093 (D. Tenn. 1977), vacated on other grounds 625 F.2d 719 (6th Cir. 1980). Note, however, that Section 1106(d) and (e) also forbid HHS from disclosing certain individual contractor performance reviews and comparative evaluations without prior notification, review and comment by the affected individual contractor. If the HCFA record associating individual physicians with patient outcomes were deemed such a performance record, Exemption 3 would apply and disclosure would be forbidden under both Section 1106 and the Privacy Act until review and comment were completed.

Note also that the argument has repeatedly but unsuccessfully been made that the Trade Secrets Act, 18 U.S.C.A. §1905 (which prohibits the unauthorized disclosure of commercial and financial information by federal employees) constitutes an Exemption 3 statute exempting release of Medicare claims data. See, e.g. Florida Medical Assn v. HEW 479 F.Supp. 1291, 1302 (M.D. Fla. 1979); Westchester General Hospital v. HEW 464 F.Supp. 236, 243 (M.D. Fla. 1979); St. Mary's Hospital, Inc. v. Califano 462 F.Supp. 315, 317 (S.D. Fla. 1978) aff'd sub. nom. St. Mary's Hospital v. Harris 604 F.2d 407 (5th Cir. 1979).

17 Washington Post Co. v. HHS 690 F.2d (D.C. Cir. 1982).

data, physicians would appear to have a similar commercial interest in data revealing their patients' outcomes, since such information could logically be expected to affect the marketability of their services. In fact, expected market impact would presumably be one of the requestor's reasons for seeking disclosure. However, unlike Public Citizen and unlike the usual Exemption 4 case, physician-identified medical record outcome data based on hospital claims would have been obtained from a hospital, not the physician. Since the purpose of Exemption 4 is to protect commercial entities submitting data to the government, it could be argued that its protection ought not to extend to physicians identified in hospital-submitted data.[18]

Assuming physician-identified data are deemed commercial and obtained from a person, whether the data are confidential depends on a two-pronged test, i.e., whether disclosure is likely to have either of the following effects: (1) to impair the Government's ability to obtain necessary information in the future; or (2) to cause substantial harm to the competitive position of the person from whom the information was obtained.[19] The test has generally been applied by the courts to exemption 4 claims on a case by case basis. With respect to impairment of government information collection, the courts have generally found no impairment where the person submitting the data was required to do so as a mandatory condition of doing business with the government. Physician-identified data based on Medicare billings claims would appear to constitute data submitted under mandate.[20] With respect to competitive harm, court decisions can be found going both ways on the issue of competitive harm from disclosure of Medicare cost reports, which are analogous to patient outcome data.[21] In the author's view, no competitive harm is present

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18 In a way, the case of physician-identified data submitted by a hospital is like that of commercial and financial information on private parties obtained or generated by the government itself. The courts have held that such information does not fall within Exemption 4 because it has not been "obtained by a person". See, e.g. Board of Trade v. Commodity Futures Trading Comm'n 627 F.2d 392, 404 (D.C. Cir. 1980). See also Public Citizen Health Research Group v. HEW 477 F.Supp. 595 (D.D.C. 1979), rev'd on other grounds 668 F.2d 537 (D.C. Cir. 1981) (PSRO medical care evaluation studies not exempt from disclosure under Exemption 4, because studies do not contain "commercial information" or "trade secrets" of PSRO.)

19 National Parks & Conservation Ass'n v. Morton 498 F.2d 765, 770 (D.C. Cir. 1974).

20 See Florida Medical Ass'n v. HEW 479 F.Supp. 1291, 1303 (M.D. Fla. 1979) (no impairment where information contained in Medicare claims form required to obtain reimbursement).

21 E.g., Florida Medical Ass'n, supra at 1303 (no substantial harm); Parkridge Hosp. v. Blue Cross and Blue Shield 430 F.Supp. 1093, 1096-7 (E.D. Tenn. 1977) (substantial harm found).

when physician-identified information is made available about all physicians. Every physician is affected equally, and any competitive harm comes not from selective disclosure, but from shifting consumer preference based on data disclosed equally as to all.[22]

Exemption 6

FOIA Exemption 6 applies to "personal and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." Exemption 6 offers a classic example of the jurisprudential technique of interest weighing and balancing described in the introductory section of to this report. Exemption 6 requires a weighing of the individual's interest in privacy against the public interest served by disclosure.[23] Because the statute states that nondisclosure is permitted only when disclosure would constitute a "clearly unwarranted" invasion of privacy, the courts have concluded that Congress intended the scales to be tipped in favor of disclosure.[24] Before the balancing test is applied, an initial assessment must be made whether disclosure would in fact threaten a protectable individual privacy interest. If such an interest is identified, balancing is undertaken.

Under Exemption 6 the courts have vigorously protected disclosure of intimate personal details of individual lives, such as marital status, legitimacy of children, medical condition, welfare payments, family fights and reputation, etc.[25] There are decisions indicating that a person's interest in nondisclosure of information that could be characterized as "professional" rather than "personal" either does not constitute a privacy interest[26] or occupies a relatively weak position in the balance.[27] However, physician-identified information that certainly appears more "professional" or commercial than personal has been protected from disclosure under Exemption 6. In Florida Medical

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22 This view is endorsed in dicta in Westchester Gen. Hosp. v. HEW 464 F.Supp. 236, 245-46 (M.D. Fla. 1979).

23 Dept. of Air Force v. Rose 425 U.S. 352, 96 S.Ct. 1592 (1976).

24 Hrones v. C.I.A. 685 F.2d 13, 19 (1st Cir. 1982).

25 Rural Housing Alliance v. U.S. Dept. of Agriculture 498 F.2d 73, 77 (D.C. Cir. 1974).

26 Sims v. Central Intelligance Agency 642 F.2d 562, 574 (D.C. Cir. 1980); Cohen v. E.P.A. 575 F.Supp. 425, 429 (D.C.D.C. 1983), But see Professional Review Org. v. HHS 607 F.Supp 423, 427 (D.C.D.C. 1985) (professional credentials and other personal information in resumes give rise to legitimate

27 privacy concern under Exemption 6).
Kurzon v. HHS 649 F.2d 65, 69 (1st Cir. 1981); Public Citizen Health Research Group v. HEW, supra note 18 (physician privacy interest in nondisclosure of PSRO data, while genuine, not entitled to same weight as interest of individuals in nondisclosure of intimate, personal information).

Assn. v. HEW 479 F.Supp. 1291, 1304-5 (M.D. Fla. 1979) the Court held that the amounts of Medicare reimbursement received by individual physicians was "traditionally confidential and personal information about at least part of those individuals' gross incomes," and under Exemption 6 not subject to disclosure.

In the author's view there are several "interests" and arguments that might be cited by physicians seeking to resist disclosure of medical record outcome data. First, physicians could claim an interest in protecting themselves and their professional reputations from misleading publicity and possibly unwarranted professional and public criticism. To avoid the characterization of this interest as a commercial interest in protection of their business reputation, physicians might argue that in the eyes of the public, their professional and personal selves were indistinguishable, so that harm to a physician's professional reputation would necessarily harm his/her personal reputation. Second, and in a related vein, physicians could argue that the reputational injury they might suffer could intrude upon or harm their confidential relationship with patients, by diminishing patient trust and willingness to confide personal medical details to them. Third, pointing to[28] HHS' prohibition on release of physician-identified PRO data physicians might argue that the existence and importance of their privacy interest in physician-identified outcome data was recognized elsewhere in federal law, and that similar recognition ought to be granted under the FOIA.[29] Fourth, physicians might argue that the prospect of release of physician-identified outcome data would discourage physicians from participating in Medicare, and that there might therefore be a public interest in non-disclosure. Fifth, physicians might argue that at least one purpose of disclosure-exclusion of low-quality physicians from treatment of Medicare patients-could be accomplished directly by HHS through decertification to participate in medical care, obviating the need for the harsher, less narrowly-tailored remedy of disclosure of information. Finally, physicians could argue that physician-identified outcome data was such a poor predictor of future physician performance that the public benefit from disclosure was minimal.

In opposition to these arguments, a proponent of disclosure might raise the following arguments: First, a disclosure proponent could argue that the physician interest in nondisclosure was either a commercial interest unprotected by Exemption 6 or a personal interest not entitled to great weight in the Exemption 6 balance, because information about patient outcomes lacked the personal intimacy or risk of immediately personal impact present

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[28] See discussion infra p. 15.

[29] Policies announced in other federal statutes are often considered in the Exemption 6 balancing equation. See, e.g. Common Cause v. Nat'l Archives 628 F.2d 179, 183-85 (D.C. Cir. 1980).

in privacy interests strongly guarded by Exemption 6. Second, a disclosure proponent could argue that protection of the health of the citizenry is a paramount public interest. Disclosure of physician-identified medical record information to Medicare beneficiaries and other consumers and consumer representatives could logically be expected to advance the public health by steering patients away from practitioners with higher expected future patient death, morbidity, or other adverse outcomes. Third, by allowing market forces to exclude low-quality providers public release of physician-identified outcome data might be less personally and professionally stigmatizing to individual physicians than the alternative of licensure revocation, exclusion from Medicare participation, or official discipline. Fourth, the physicians most likely to exit the Medicare program as a consequence of outcome data disclosure would be low-quality physicians, in whose continued Medicare participation the public interest was weak. Fifth, it could be argued that the reliability of outcome data as a predictor of future performance could best be improved, and consumers ability to use such information best achieved, if the information were disclosed.

Competing arguments such as these pro and con medical quality data disclosure were once specifically litigated. In Public Citizen Health Research Group v. HEW[30] a consumer organization (Public Citizen) requested PSRO data under the FOIA, including data linking individual physicians with patient mortality outcomes. Public Citizen expressly disavowed any request for patient-specific information. The trial court granted Public Citizen the right to obtain the data. The Court held, among other things, that the PSRO was a federal agency subject to the FOIA and that the information was not exempt under Exemption 6. On the latter issue, the PSRO, HEW, and others opposing Public Citizen, argued that physicians had a privacy interest in nondisclosure to avoid reputational injury, and that disclosure could diminish physician participation in the PSRO process and in Medicare and Medicaid. Public Citizen argued that release of the information would assist consumers in making informed choices among individual physicians. It also argued that disclosure would variously aid consumers in monitoring the PSRO, physicians in referring patients, health planning/licensure/reimbursement agencies in performing their functions, and academics in conducting research on health care delivery. The Court ruled that physicians' privacy interest in nondisclosure was not of the same magnitude as an interest in nondisclosure of intimate, personal data. It also concluded that the interests cited by Public Citizen were important public interests, closely related to a goal at the core of the FOIA: scrutinizing government performance. It dismissed the concern over physician flight from PSRO's and federal reimbursement programs as speculative, and intimated that physicians participating in governmental medical care reimbursement programs voluntarily surrendered privacy

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[30] Supra note 18.

interests they might otherwise possess. Finally, the Court observed that "[d]isclose of a physician's identity does nothing to intrude on his confidential relationship with patients, nor does it restrict the exercise of his professional medical judgment."[31]

Although suggestive as to how a court today might view an FOIA request for physician-specific mortality data, the Public Citizen case unfortunately has little or no value as legal precedent. Its holding that PSRO's were "federal agencies" (a necessary prerequisite to its ruling on FOIA exemption) was reversed by the U.S. Court of Appeals in 1981, and while an appeal the Supreme Court was pending, the same ruling was effectively rendered moot by the passage of the PRO Act, which specifically exempts the PSRO's successor, PRO's, from the FOIA.

If a court today were to conclude in a FOIA case involving physician-specific data that the balance favored disclosure and no FOIA exemption applied, it would probably then conclude that since the information was required to be released under the FOIA, the Privacy Act did not forbid disclosure without the physician's consent. Having reached such a conclusion, the court would permit the data to be released.

Voluntary disclosure by HHS

Would the analysis under the FOIA and Privacy Act be different if HHS were to propose to release physician-identified data on its own initiative? Probably not. In fact, disclosure might be more acceptable to the courts if HHS proposed blanket disclosure of identical information about all physicians than if a requestor sought information about only some physicians, since HHS disclosure would affect physicians equally rather than selectively.

Non-Medicare data

Some non-Medicare, physician-identified medical record outcome data may be collected by the National Center for Health Statistics. NCHS obtains death statistics from state vital statistics collection systems, and from time to time may purchase, or receive voluntarily from hospitals, discharge abstract data for use in the National Hospital Discharge Data Survey. These data may link an individual physician with a patient death, but individual patient and physician identities are usually stripped from the data before NCHS receives them.[32] Since the data originate with state and private collection systems, legal issues relating to them will be considered in connection with the discussion below of data collection and dissemination by state agencies and private parties.

[31] Public Citizen supra note 18 at 605.

[32] Author's personal communication with Jane Walsh, Director of Technical Services, Western Consortium for Public Health.

2. Collection and dissemination by federal contractors

Private organizations under contract to HHS may collect physician data. First, private Medicare fiscal intermediaries and carriers are the initial collection point for Medicare claims data. Fiscal intermediaries[33] and carriers are not "federal agencies" subject to the FOIA. However, HHS has subjected them to the same set of requirements as it is subject to, by applying its FOIA/Privacy Act/Section 1106 regulations to them.[34] The legal issues surrounding collection and disclosure of Medicare information by intermediaries and carriers should therefore be substantially the same as those that apply to collection and dissemination by HCFA.

3. PRO data collection and dissemination

A more important system of Medicare data collection by federal contractors is that collected by Utilization Review and Quality Control Peer Review Organizations, commonly known as PROs. PROs are statewide organizations that operate with physician sponsorship or participation for the primary purpose of providing utilization review and quality control functions under contract to HCFA.[35] Their functions include review of the professional activities of physicians, hospitals, and other health care professionals and providers to assure that payment is made only for services that are medically necessary, delivered in the most appropriate setting, and meet professionally accepted standards of patient care quality. PROs may also perform private peer review, DRG validation, outlier review, and admission pattern monitoring. In connection with several of these activities, most notably quality review activities under their federal contract, PROs may collect, acquire, or generate physician-identified mortality data.

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33 Health Systems Medical Supply, Inc. v. Blue Cross-Blue Shield of Alabama et. al. No. CA.77-P-0988-NE (U.S.D.C., N.D. Ala., Nov. 2, 1977, CCH MEDICARE & MEDICAID GUIDE ¶ 28,900.

34 42 C.F.R. §401.101(a) (1986).

35 The existence, roles and responsibilities of PROs are set forth in a series of federal enactments, i.e., Peer Improvement Act of 1982 (P.L. 97-248), Social Security Amendments of 1983 (P.L. 98-21), Deficit Reduction Act of 1984 (P.L. 98-369), Consoldated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), and Sixth Omnibus Reconciliation Budget Act of 1986 (P.L. 99-509), all of which are codified in the Social Security Act, §§1151-63 and related sections, 42 U.S.C.A.§§1320c through c-12 (1983 & Supp. 1987). Regulations relating to PROs are codified at 42 C.F.R. Parts 405, 462, 466, 473, 474, 476 and related sections (1986). A good general source of information about PROs and their role in Medicare, including the above-noted statutory and regulatory provisions, is the Commerce Clearing House (CCH) Medicare and Medicaid Guide.

The FOIA and Privacy Act rules do not apply to PROs. They are categorically exempt from those statutes.[36] Instead, the federal PRO statute and regulations contain their own unique requirements for acquisition, protection, and disclosure of data collected, acquired, or generated by PROs. Generally, they prohibit disclosure of any data or information acquired by a PRO except under certain specified circumstances, and require prior notification of the fact of disclosure to an identified patient, health care practitioner, or institution.

The federal requirements classify information acquired by PROs into two categories: confidential and non-confidential information. "Confidential information" includes information that explicitly or implicitly identifies an individual patient, health care practitioner, or PRO reviewer. It also includes quality review studies which identify patients, practitioners, or institutions.[37] "Nonconfidential information" is all information that is not defined as confidential, and includes public information in the PRO's possession and aggregate statistical information that does not implicitly or explicitly identify individual patients or practitioners. Information that explicitly or implicitly identifies an individual health care facility or institution is not confidential.

PRO duty of nondisclosure

PROs are not permitted to disclose confidential information to the public, either voluntarily or on request.[38] Thus, a PRO may not disclose aggregate statistical information on practitioner outcomes, or information that implicitly identifies an individual patient or practitioner. An individual making such an unauthorized disclosure could be subject to a fine or imprisonment, or both.

However, under certain limited circumstances PROs may be permitted or required to disclose confidential information of various types to HCFA and other federal, state, and local investigatory, public health, licensing, and certification agencies, fiscal intermediaries, individual patients, practitioners, and institutions.

PRO disclosure to DHHS

First, the PRO regulations require PROs to disclose all confidential information requested by HHS, in the manner and form

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[36] Soc. Sec. Act §1160(a); 42 U.S.C.A. §1320c-9.

[37] 42 C.F.R. §476.101 (1986). Certain sanction reports and PRO deliberations are also deemed confidential.

[38] See generally Soc. Sec. Act Sec. 1160; 42 U.S.C.A. §1320c-9; 42 C.F.R. §476.130 et. seq. (1986).

required.[39] Physician-identified medical record outcome data collected by the PRO, or available in raw data in the possession of the PRO, could thus be obtained by HHS.

HHS redisclosure

Would DHHS be either required or permitted to redisclose such information to consumers or consumer representatives? The answer requires an analysis of applicable FOIA and Privacy Act requirements. Initially, it is important to recognize that DHHS could not be compelled under the FOIA by a consumer or consumer representative to obtain physician-identified information from the PRO in order to pass it along to the requestor. The FOIA requires disclosure of information in the hands of federal agencies, but does not impose any information-gathering requirements of its own. If, however, HHS were to obtain such information, the Privacy Act exception would forbid its disclosure without the consent of the individual physician unless the information fell within a Privacy Act exception. The most likely applicable exception would be for material required to be released by the FOIA. As indicated above, the FOIA requires all information to be released unless it falls within one of several exemptions. The most likely applicable FOIA exemptions would be exemption 6, (files the disclosure of which would constitute a clearly unwarranted invasion of privacy) or exemption 4 (confidential commercial information).[40]

If the information were not exempt, HHS could be required to disclose it. Could HHS voluntarily disclose it? Legally, yes. Whether it would choose to do so, at least at the present time, is another matter. If HHS intended that such information be released to consumers and consumer representatives, it seems likely that HHS would have simply authorized the PROs themselves to release it. Instead, the PRO disclosure regulations forbid PROs from releasing physician-identified information to the general public. In fact, the regulations embody a presumption that information which identifies an individual physician is "confidential". It is hard to envision HHS concluding that certain information was confidential and nondisclosable to the general public when in the possession of a PRO, but nonconfidential and disclosable when in the hands of a federal

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[39] 42 C.F.R. §476.130 (1986). Limited exceptions to this rule are provided for PRO deliberations and quality review studies.

[40] See discussion of FOIA exemptions 4 and 6 supra.

agency.[41] Finally, in the preamble to the final PRO regulations published in the Federal Register, HHS indicated that although information disclosed by the PRO to the Department would be subject to redisclosure under the FOIA, HHS does not intend to routinely request practitioner-identified information.[42]

PRO disclosure to public health agencies

The PRO statute and regulations provide that PROs may, and in certain circumstances must, disclose confidential information to state agencies recognized by HHS as having responsibility for identifying cases or patterns involving risks to the public health.[43] A PRO must disclose such information, which could include physician-identified medical record outcome data, whenever it determines that the disclosure is necessary to protect against a substantial risk to the public health.[44] The PRO may disclose such information upon request from the public health agency, if the agency has made a finding, or has a reasonable belief, that there may be a substantial risk to the public health.[45] In addition, the information could be redisclosed by the state public health agency to consumers or consumer representatives.[46] However, disclosure to public health agencies does not appear to be a likely vehicle for regular transmission of comparative physician quality information to the public, or representatives of the public. The "substantial risk to public health" standard for release (which HHS initially interpreted to require a finding of "imminent danger" to the public,[47]) probably encompasses release of a very limited amount of physician-identified information. It would appear to allow

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41 In fact, the preamble to the Final PRO regulations contains a lengthy discussion by HHS of the rationale for prohibition on general release of practitioner-identified information. According to HHS, "...[G]eneral disclosure is inappropriate. The potential is great for such information to be misinterpreted and misused. Public disclosure of PRO data about identified physicians could be misleading, perhaps with significant damage to reputations and practices. Releasing information that may damage the reputation of practitioners is particularly troublesome because even if the information is completely accurate, it may not fully describe all the factors relevant to a practitioner's practice. ...Furthermore, the general disclosure of practitioner-identified information could reduce the effectiveness of the peer review process under the PRO program." 50 Fed. Reg. 15355 (April 17, 1985).

42 50 Fed. Reg 15352 (April 16, 1985).

43 Soc. Sec. Act §1160(b)(1)(B).

44 42 CFR 467.138(a)(2) (1986).

45 Soc. Sec. Act §1160(b)(1)(B)(i).

46 State FOIA or other confidentiality requirements would apply to such disclosure. See infra p. 19.

47 See proposed 42 C.F.R. §476.138(b), 49 Fed. Reg. 1497__ (April 16, 1984).

release of information about an individual practitioner whose patient outcome experience indicated a significant risk to the physician's future patients, but not to allow general release of outcome information about all practitioners, or information about the relative risks to patients of choosing between several physicians, all of whom had relatively low (but different) patient outcome rates.

PRO disclosure to licensing and certification bodies

The PRO regulations also permit and/or require disclosure to state medical or facility licensing boards. Disclosure is required upon request, and may be provided without request. However, the scope of confidential information subject to disclosure is limited to that which is required by the receiving agency to carry out its functions under state law. This limitation would probably limit the utility of release to licensure boards as a vehicle to convey information about all practitioners to consumers, since the responsibilities of licensure boards are usually limited to policing individual physicians, and do not encompass consumer education or information dissemination.

4. State government collection and dissemination of medical record outcome data

State government agencies may collect physician-identified outcome data. Twenty-eight states have statewide health facility data commissions which collect hospital discharge data, in the Uniform Hospital Discharge Data Set format or other formats containing discharge disposition and attending physician fields.[48] For example, recent Pennsylvania legislation creates an independent Health Care Cost Containment Council, with authority to collect comprehensive hospital and physician data, including hospital discharge data, and data which can be used to compare mortality, morbidity, and infection rates for specified diagnoses and treatments for all individual physicians in the State.[49] Sixteen other states have some form of health care utilization and cost data reporting system providing for dissemination to consumers and purchasers, and eleven other states have more limited data sets and dissemination practices.

Dissemination of state data commission information may be subject to state "freedom of information" statutes. State FOIA statutes vary, both in the scope of mandated disclosure and exceptions therefrom. In a general sense, however, they follow

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[48] Larks, Access to Health Data by State Health Data Organizations and Quality Assessors 1 (1987) (Contractor document prepared for the Health Program, Office of Technology Assessment), (hereinafter "Larks".)

[49] PA. STAT. ANN. tit 35, §§449.1 et seq. (Purdon 1987 Cum. Ann. Pocket Part), hereinafter "Pennsylvania statute".

the approach of the federal FOIA, and the question of disclosure of physician-identified outcome data under a state FOIA would probably be analyzed in the same manner as under the federal FOIA, as described above.[50]

Dissemination of state data may also be regulated by the confidentiality provisions of the statutes establishing the state data systems. The Illinois statute, for example, exempts health facility data collected by the state data agency from the state FOIA, and subjects it to restrictive limitations.[51] The majority of states have similar provisions.[52] The Texas health facility data collection statute, which mandates the collection of uniform hospital discharge data that identifies individual physicians, provides that before the agency may disclose any data it must remove information that would identify a specific patient, physician, or health facility.[53]

The majority of states appear to restrict or prohibit the release of physician-specific medical record outcome data by their data agencies.[54] However, the restrictions are not universal. The Pennsylvania statute, for example, requires the data commission to prepare and issue to the state legislature and the general public for every hospital, physician and ambulatory service facility in the state, for major inpatient and outpatient services, the following information:

> Comparisons among all providers, grouped according to diagnosis, procedure, and severity, which identify facilities by name and type and physicians by name and specialty, of charges and payments received, readmission rates, mortality rates, morbidity rates, and infection rates.[55]

The statute also authorizes the state data commission to develop additional measures of physician, hospital, and ambulatory facility quality and service effectiveness. The Pennsylvania

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50 See, e.g. United States v. Collins 546 F.2d 166 (6th Cir. 1979) (disclosure of nursing home Medicaid cost reports to Dept. of Justice was not a release of "personal information" forbidden under Ohio Privacy Act); Cragmont Care Center v. Dept. of Soc. Serv. 325 N.W.2d 918 (Iowa App. 1982) (release of nursing homes' Medicaid cost reports was permissible under state FOIA). A state-by-state analysis of state FOIA statutes may be found in FRANKLIN & BOUCHARD, GUIDE BOOK TO THE FREEDOM OF INFORMATION AND PRIVACY ACTS (State Statutes Appendix) (1987).

51 Larks, supra note 48 at Appendix B.

52 Id.

53 TEX. REV. CIV. STAT. ANN. art 4438e, §7(a) (Vernon 1987 Cum. Ann. Pocket Part).

54 Larks, supra note 48 at Appendix B.

55 Pennsylvania statute, supra note 49, at Section 7.

statute embodies a strong preference for disclosure of comprehensive quality-related information to health care consumers, and appears to be by far the most pro-disclosure law on the books in any jurisdiction.[56]

State health facility rate-setting agencies and Medicaid agencies may also obtain physician-specific outcome data. The release of data by such agencies is likely to be controlled by the same principles as apply to state health facility data commissions.

5. Collection and dissemination by private organizations

Private organizations may collect physician-specific medical record outcome data. For example, private health insurers may require billing reports similar to those required by the Medicare program. Hospitals may collect such information, either generating it themselves or using a private medical record abstracting service. In addition, JCAH accreditation requirements or state health facility licensure regulations may compel hospitals to undertake ongoing quality review and control procedures which generate physician-specific data.

In the absence of a statutory reporting mandate, such as the requirement to report information to a state data commission or to provide certain information in connection with billings, private organizations are under no legal obligation to provide information to consumers or other outsiders. In fact, they are likely to be legally bound not to do so. Insurers, for example, typically agree contractually with providers not to disclose information submitted to them in connection with billings, and the release of such information could subject insurers to liability for breach of contract. Private information collectors may also face tort liability for release of such information. Individual physicians could bring a variety of actions against them. Although truth is a defense to such a claim, physicians could argue that such a release was defamatory, e.g., injurious to their reputation. They could also argue that release constituted a common-law invasion of privacy, infliction of emotional distress, or a form of business tort.[57]

Peer review confidentiality

State statutes may also expressly forbid disclosure. An increasing number of states have adopted laws exempting from mandatory disclosure in litigation the records and proceedings of organized medical committees in hospitals or local medical societies having the responsibility for evaluation and improvement of quality of care.[58] Such statutes could cover in-

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[56] See "Landmark Health Data Law Enacted in Pennsylvania," NAHDO NEWS (Nov. 1986).

[57] See PROSSER & KEETON, TORTS §§117, 128-30 (1985).

[58] See, e.g. CA. EVID. CODE §1157 (Deering 1986).

hospital medical record outcome data, if collected as part of an in-hospital peer review process. The purpose of such statutes is to encourage full and free discussion in hospital or medical society peer review committees in order to foster health care evaluation and improvement.[59] The statutes have been criticized, however, as depriving medical malpractice plaintiffs of evidence necessary to prove claims of negligence by hospitals in supervising the quality of care provided by physicians on their medical staffs. The dilemma imposed by such statutes is that the shield of confidentiality they erect to encourage peer review deprives the public of the means to ascertain whether such peer review is being effectively carried out. Proponents of disclosure of quality of care-related information to technical intermediary organizations rather than directly to consumers would do well to consider this dilemma, since their proposals would run afoul of the same problem.

B. Adverse Events in Hospitals

Information about "adverse events" or unexpected mishaps in hospitals may be collected by various sources.

1. Federal agencies and contractors

No federal agency currently collects information on adverse events in hospitals. However, PROs may collect such information. PROs are required to review the quality of care provided by hospitals participating in Medicare, including taking steps to eliminate adverse outcomes by subjecting cases under review to generic quality screens. A record of cases failing to pass the generic screens would be a record of adverse events.[60]

Disclosure of PRO data on adverse events in hospitals is subject to the same rules as govern other releases of PRO data. Confidential information (e.g. information that identifies an individual patient or physician) may not be disclosed to the general public, and may be disclosed only to certain specified parties in specific circumstances. Generic quality screen information probably constitutes "quality review study" information,[61] a special category of information under the PRO regulations. As such, it may be disclosed onsite at the PRO offices to HCFA, the GAO, the Office of the Inspector General of HHS, federal and state fraud and abuse enforcement agencies,

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59 Brown By and Through Brown v. Superior Court, 168 Cal. App. 3d 489, 214 Cal. Rptr. 266 (1985).

60 See generally PRO Scope of Work (for contracts entered into 1986-1988) reprinted in CCH MEDICARE & MEDICAID GUIDE ¶12, 872.

61 The PRO regulations define "quality review study" as an assessment, conducted by or for a PRO, of a patient care problem for the purpose of improving patient care through peer analysis, etc. 42 C.F.R. §476.101(b) (1986).

state-authorized licensure, accreditation, and certification agencies, and federal and state public health agencies when there is a substantial risk to the public health. It may not be disclosed in civil court proceedings, with certain exceptions.[62] The legal restrictions on redisclosure by the foregoing agencies are the same as those that would apply to their redisclosure of PRO mortality data.

2. State and private collection and dissemination

State health facility licensure agencies may collect information on adverse events in hospitals. According to the GAO, six states presently require incident reporting by hospitals.[63] The availability of state health facility licensure data is likely to be controlled by state FOIA laws.[64] Private organizations, most notably hospitals themselves, may collect and compile adverse event data. Typically, hospital "risk management" systems collect such information.[65] In the absence of statutory reporting requirements, they have no obligation to disclose such information. Additionally, disclosure may be forbidden under state peer review confidentiality statutes.

C. Official Disciplinary Actions

Official disciplinary actions are actions taken by state medical licensure agencies to sanction or discipline physicians. Such actions may be taken for a variety of reasons, including persistent substandard quality care.

1. Federal government collection and dissemination

The federal government has not traditionally collected information from state medical licensure agencies. However, an important new federal statute may change this. The "Health Care Quality Improvement Act of 1986" was enacted to promote professional medical peer review activities and restrict the ability of incompetent physicians to remain in practice by moving from state to state to avoid disclosure of their previous damaging or incompetent performance.[66] The most widely publicized feature of the Quality Act is a provision immunizing professional review bodies of hospitals, HMOs and local medical societies from liability under federal and state law arising out

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62 42 C.F.R. 476.140 (1986).

63 GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION (1987).

64 See discussion supra p. 20.

65 ROACH, CHERNOFF, & ESLEY, MEDICAL RECORDS AND THE LAW 178 (1985).

66 Pub. L. No. 99-660, Title IV, "Health Care Quality Improvement Act of 1986", 100 STAT. 3784 et seq. 99th Cong. 2nd Sess. (Nov. 14, 1986), reprinted in 1986 U.S. CODE CONG. AND AD NEWS (unpaginated).

of their peer review activities. Immunity from liability is contingent upon several matters, the most prominent of which is conduct of peer review in accordance with certain substantive and procedural due process standards. However, immunity is also contingent on the health care entity reporting certain professional review actions to state medical licensing boards.[67] In addition, the statute imposes information collection, reporting, and dissemination requirements on medical malpractice insurers, medical licensing boards, and HHS.

With respect to official disciplinary actions, the Quality Act requires medical licensing boards to report to HHS (or an appropriate private or public agency selected by HHS) each time it revokes, suspends, or otherwise restricts a physician's license, or censures, reprimands, or places on probation a physician for reasons relating to professional competence. Voluntary surrender of a physician's license must also be reported. Reportable information includes the physician's name and a description of the acts or omissions involved.

In turn, HHS or the designated private organization is required, upon request, to provide information about official disciplinary actions to other state licensing boards, and to hospitals and other health care entities that have entered or may be entering into employment or affiliation relationships with an individual physician, or to which the physician has applied for medical staff appointment or clinical privileges.[68]

The Quality Act contains an additional disclosure/confidentiality provision, which states:

> Information reported under this part is considered confidential and shall not be disclosed (other than to the physician or practitioner involved) except with respect to professional review activity, as necessary to carry out subsections (b) and (c) of Section 425 [which impose a presumption in medical malpractice actions of hospital acknowledgment of reported information, and entitle hospitals to rely on such information-ed.] (as specified in regulations by the Secretary), or in accordance with regulations of the Secretary promulgated pursuant to subsection (a) [which authorizes disclosure to licensing boards, health facilities, etc.-ed.] Nothing in this subsection shall prevent the disclosure of such information by a party which is

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67 See discussion infra p. 25-26.

68 An unusual provision of the Quality Act imposes an affirmative duty on hospitals to request information from HHS concerning matters reported under the Act at the time a physician applies for medical staff membership or privileges, or in any case once every two years for all medical staff members.

> otherwise authorized, under applicable State law, to make such disclosure Information reported under this part that is in a form that does not permit the identification of any particular health care entity, physician, other health care practitioner, or patient shall not be considered confidential. The Secretary (or the agency designated under Section 424(b)), on application by any person, shall prepare such information in such form[69] and shall disclose such information in such form.

The full meaning of this section is unclear. First, it is unclear whether it restricts redisclosure by HHS as well as redisclosure by licensing boards, etc.[70] Second, it is unclear what disclosure "necessary to carry out" the hospital reliance and presumption in medical malpractice actions provisions of Section 425(b) and (c) means, although it may mean that the information is sometimes discoverable by malpractice plaintiffs. Third, it is not certain what the proviso permitting disclosure by an otherwise authorized party means, although it appears to permit redisclosure by, for example, state licensing agencies upon receipt of a valid state FOIA request. It is also unclear whether the provision deeming non-identified non-confidential implicitly deems identified data confidential, either for purposes of HHS or licensing board, etc redisclosure. It is clear, however, that the only information collected under the Act which is available without limitation to consumers is that which is least useful to them, i.e., data that does not identify individual health facilities or physicians. It is likely that as collection of data under the Quality Act grows, the disclosure/confidentiality provisions will be the subject of litigation.

2. State government collection and dissemination

State medical licensing boards themselves presumably collect and compile information on their own official actions. Most voluntarily report to the Federation of State Medical Boards, a national organization of medical licensing agencies, which in turn disseminates information to licensure agencies elsewhere in the country. In addition to reporting information to HHS pursuant to the Quality Act, information concerning disciplinary actions by license boards may be publicly available through the state FOIA route.

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69 Quality Act, Section 427(b)(1), as amended by Pub. L. No. 100-177, Title IV, Section 402 "Public Health Service Act of 1987", __STAT__, 100th Cong. 1st Sess. (Dec 1, 1987), See Cong. Rec. H9480 (Nov. 3, 1987)(text of S.1158).

70 If the section applies to HHS, it would appear to constitute a specific exemption statute within the meaning of FOIA Exemption 3.

D. Unofficial Disciplinary Actions

Physicians practicing in organized medical settings, including most notably physicians with hospital staff membership and privileges, are subject to disciplinary action by the organization. For example, as required by state licensure requirements and JCAH accreditation standards, private hospitals have elaborate internal systems for reviewing applications from physicians for initial membership on the hospital's medical staff and ongoing clinical privileges. These are necessary prerequisites to admitting privileges and access to the hospital's surgery and other technical capabilities.[71] Hospitals can be liable for failure to conduct continuous review of staff physician qualifications through the staff membership and privileges process.[72] Information on the conduct of these internal policing programs has traditionally been held confidential, and as noted above, may be immune from discovery in civil litigation under state peer review confidentiality statutes. However, the recently-adopted federal Quality Act provides for limited collection and dissemination of information about staff membership and privileges proceedings.

The Quality Act requires health care entities (hospitals, HMOs, and local medical societies) to report to their state medical licensing board each time they take an action in the course of internal peer review that adversely affects a physician's clinical privileges. The report must contain the physician's name and a description of the reasons for the peer review action. The medical licensing board must in turn report such information to HHS or its designee, who in turn must report it on request to other states' licensing boards, and to hospitals and HMOs that have entered or may be entering into employment, affiliation, or medical staff membership relationships with the physician. As with records of official disciplinary action, hospitals have an affirmative duty to request such information from HHS on new staff applicants and existing staff members. Disclosure requirements are identical to those that apply to records of official disciplinary action.

E. Malpractice Judgments and Payments

A malpractice judgment is a final court decision in an action alleging professional negligence by a physician. Like any other court record, it is a public record readily available to the general public.

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71 See generally AMERICAN HOSPITAL ASS'N, ANALYSIS OF REVISED MEDICAL STAFF STANDARDS OF THE JOINT COMMISSION ON ACCREDITATION OF HOSITALS (1984).

72 Elam v. College Park Hospital 132 Cal. App.3d 332, 183 Cal. Rptr. 156, mod. 133 Cal. App.3d 94a (1982).

Government agencies have not traditionally collected data on malpractice decisions. However, the new federal Quality Act establishes a mechanism in federal law for collection and limited dissemination of such information. The Act provides that health care entities and insurance companies which make payment under a policy of insurance or self-insurance, or in settlement or satisfaction of a judgment in a medical malpractice action or claim, must report information thereon to the Secretary or his designee. Reported information includes the physician's name, the amount of payment, and a description of the acts and omissions or injuries upon which the action or claim was based. Unlike the other provisions of the Quality Act which provide either for no enforcement or enforcement through denial of the immunity from liability provisions of the Act, failure to report malpractice information is subject to a substantial fine. As with reporting of disciplinary proceedings, HHS is required to make physician-identified information available to health care entities and licensing boards, and hospitals are required to obtain the information from HHS. Given the fact that malpractice information (at least in cases resolved through litigation) is already available to the public in raw data form, the reason for restricting disclosure of compilations of such data to consumers is not readily apparent.

Some state laws may require reporting of malpractice judgments to medical licensing boards, from whom survey information would be available through a state FOIA request. Various private attorney's services also collect information on malpractice judgments, and sell it to malpractice lawyers for a fee. In-hospital quality assurance systems, HMOs and PPOs, and health and malpractice insurers may privately collect such information, but other than as provided in the Quality Act, they have no disclosure obligations.

III. LEGAL IMPLEMENTATION OF POLICY OPTIONS

As Section II of this report demonstrates, there are several existing systems for collection of data on physician-specific medical record outcome, adverse events in hospitals, official and private disciplinary actions, and malpractice judgments. Outcome data are collected by HCFA, PROs, and data commissions in a significant number of states. Adverse event data are collected by PROs and a few states. Data on official and unofficial disciplinary actions are collected by medical licensing boards and HHS under the Quality Act. Information on malpractice payments is also collected by HHS under the Quality Act.

By and large, however, this information is legally not available for release to consumers. Outcome data collected by HCFA may be available under the FOIA, but the legal authority for release is not certain. PRO physician-specific outcome data cannot be released. State-collected data may be available in some jurisdictions. Adverse event data collected by PROs are unavailable. Quality Act data such as information on disciplinary actions and malpractice payments probably cannot be obtained, unless available from HHS through the FOIA.

The reasons for unavailability of the information vary. In the case of data from Medicare claims, the medical record outcome data are part of a reimbursement and claims data system, not formatted or prepared for consumer information use. In the case of PRO data, HHS has decided not to make the data available to consumers, apparently because of concerns about reliability and the potential for reputational harm to physicians, and concern that release could discourage physicians from participating in Medicare or in peer review programs. In the case of Quality Act data, the statute appears to be narrowly focussed on problems of information-sharing among government regulatory agencies and professional self-policing groups, not on public data disclosure.[73]

In fact, the Quality Act embodies the presumption that the quality of medical care is best preserved by increasing the effectiveness of regulatory mechanisms rather than increasing the flow of information to consumers and purchasers. Although the PRO Act's disclosure provisions for hospital-specific data reflect the opposite view, its limitation on disclosure of physician data aligns it with the Quality Act's approach. By contrast, the Pennsylvania data statute embodies a very strong preference for public disclosure.

Rewriting statutes and regulations to allow disclosure of currently-collected, physician-identified information would not

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[73] The Quality Act is apparently even more restrictive than the PRO Act in disclosure to consumers, since unlike the PRO Act it does not allow disclosure of hospital-specific information.

be technically difficult. Release of outcome data based on Medicare claims might not require a statutory amendment, just a change in policy by HHS. HHS could accomplish the release of PRO data on outcomes and adverse events by amending the PRO disclosure regulations, on the basis of a finding that disclosure was necessary to carry out the purpose of the PRO statute or desirable to assure adequate protection of the rights and interests of Medicare patients.[74] Alternatively, HHS could demand the data from the PROs and then redisclose under the FOIA. Additionally, Congress could amend the PRO statute to mandate such disclosure.

In the case of state-collected outcome and other data, statutory changes also might not be necessary. In states such as Pennsylvania, disclosure is already the rule. In other jurisdictions release of data may be permissible under state FOIA provisions. States such as Texas, however, would have to amend the confidentiality provisions of their data commission laws.

Data on official and non-official disciplinary actions and malpractice claims collected under the Quality Act could not be made available by HHS or its designee private agency without an amendment to the confidentiality provision of the Act, unless the provision were interpreted not to apply to HHS redisclosure. However, redisclosure by state licensing boards of information received from HHS or its designee could be possible without statutory change, if permissible under state FOIA or other confidentiality laws.

How could the federal government accomplish these changes? Obviously, to the extent disclosure requires federal statutory or regulatory changes, Congressional or HHS official action would be required. Similarly, state law changes would require action by state officials. However, the federal government could encourage states to increase their physician-identified information disclosure efforts, or discourage states from preventing such disclosure. For example, Congress could enact comprehensive legislation occupying the field of collection and dissemination of physician-identified quality of care data. The legislation would render contrary state law on the topic void.[75]

An alternative would be for Congress to adopt legislation providing financial incentives to states to enact disclosure laws providing for release of physician-identified information. Although a substantial minority of states have adopted health data commission statutes, not all have done so. In addition, data collected by existing state data commissions are not uniform. The federal government has an interest in having a

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[74] See Soc. Sec. Act §1160(a); 42 U.S.C.A. §1320-9(a), which sets forth such statutory limits on disclosure of PRO data.

[75] U.S. CONST., ART. VI §2. See generally 16 AM.JUR. 2d CONSTITUTIONAL LAW §70 (1979).

uniform health facility and provider financial and utilization data set collected by every state in the country. The availability of such data would increase the ability of the government to design, monitor, and research federal health care programs operating nationwide. It would make it possible to measure the effects of other federal actions on health care delivery throughout the country. The federal government might therefore have an interest in legislation providing federal financial support to state data commissions, on the condition that they engage in certain standardized information collection and dissemination practices. Included among these could be requirements for disclosure of physician-identified quality data. For example, the federal statute could mandate collection of discharge data in accordance with UHDDS, and require that Quality Act data be submitted to state health data commissions. This would bring all of the types of information discussed in this report into the hands of a single agency in each state. Uniform national disclosure would benefit consumers and major purchasers of medical care as well.

As an alternative to direct disclosure to consumers, physician-identified information could be disclosed to a technical intermediary organization with responsibility for deciding whether, to what extent, and in what circumstances to disclose information to consumers. In a sense, some of the existing statutes described in this report follow such a model. HCFA, as the technical intermediary recipient of physician-identified mortality data in Medicare claims, has the authority to analyze, compile, and (assuming the FOIA and Privacy Act allow it) selectively release data. PROs function like a technical intermediary, although control over whether their physician-identified information is disclosed resides with HHS. Subject to state FOIA requirements, state medical licensing agencies who receive Quality Act data are technical intermediaries in a chain of data flow from hospitals, insurers, and sister licensure agencies to HHS or its designee, thence to the licensing agencies and finally to consumers.

The concept of a technical intermediary has certain advantages. The intermediary may be able to compile and array data in a way that increases its utility to consumers. The intermediary may be able to withhold release of erroneous or misleading information-protecting the private interests of physicians and the public interest in avoiding consumer confusion or misjudgment. The intermediary could also serve as the government's agent for administration of procedural due process-type rules to protect against unannounced or inaccurate disclosures. PROs, for example, perform such a function at present with respect to Medicare sanctioning of physicians and disclosure of nonconfidential hospital-specific outcome data.

However, the concept of a technical intermediary also presents certain problems. Someone has to select and evaluate the intermediary. A major premise behind increased consumer

information disclosure, put forth in the introduction to this report, is dissatisfaction with intermediaries or agents for consumers in the medical marketplace, at least those with interests potentially in conflict with consumers' interests. If the purpose of disclosure is to convey information more directly to patients, the interposition of a technical intermediary may be inconsistent. Additionally, if consumers already utilize agents or representative for quality evaluation such as their health insurers, health plans, or employer's health benefits administrators, there may be no need for an additional layer of intermediaries between the data and the consumer.[76] The wisdom of using a technical intermediary turns less on legal issues than on judgments about the "quality" of quality data, the ability of consumers to respond appropriately to information, and the degree to which society is willing to tolerate consumer misunderstanding of data and inequitable treatment of some physicians for the sake of increasing competition on a quality basis through consumer choice.

The choice of a federal intermediary probably also ought to turn on whether the release of data would create a new, secondary market in private technical intermediary services, i.e., private services to summarize and analyze information for consumers. For example, in some cities with large concentrations of federal civil service employees, private companies have sprung up offering to analyze government worker's FEHBP health insurance options for a small fee. Similarly, in some parts of the country competing prepaid health plans pay information brokers a fee to conduct consumer seminars (typically for the employees of large employers with multiple-choice health benefit plans) at which information about each plan is presented. It is possible that information on physician quality would trigger the creation of similar organizations.

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[76] The extent to which one was convinced insurers, health plans, and employers could best serve the role of technical intermediary and interpreter of quality data would probably turn on such factors as the competitiveness of the health insurance/health plan market and the identity of alternative technical intermediaries. For example, if the proposed technical intermediary for a region with many competing health insurers and plans were a physician-controlled organization, one might prefer to let the insurers and plans compete for enrollees on the basis, among other things, of the effectiveness of their use of quality data. One might feel differently, however, if a region health insurance market was dominated by a physician-controlled plan and the proposed intermediary were an independent agency like a state data commission.

Conclusion

The fundamental choices concerning collection and disclosure of physician-identified quality data are matters of political economy and public policy. However, the choices made are likely to be carried out in a complex legal environment, with laws and legal rules describing and circumscribing data collection and release. This report has described the legal issues surrounding data collection and disclosure and identified changes in existing law necessary to effectuate expanded disclosure.